2000

Research Highlights

Partners in Care

Hope for Those Who Struggle with Hope

Over the next decade, depression is expected to become the second-leading cause of disability worldwide. About 20 percent of all primary care patients have significant symptoms of depression and require further assessment and patient education. About 6 percent of primary care patients are clinically depressed and require antidepressants or psychotherapy. National clinical guidelines define appropriate treatment strategies for this highly treatable condition, but studies over the past decade have consistently found low rates of detection and appropriate treatment in primary care, the setting from which most depressed persons seek care, if at all.

Partners in Care is a real-world trial to determine whether diverse primary care practices can implement previously tested, effective models of care for depression. A collaborative effort of researchers and clinicians at many institutions, the study involves more than 27,000 patients, 125 providers, and 46 primary care clinics within six nonacademic managed care practices in various locations across the United States.

The messages emerging from this study are hopeful ones. For patients: their mental health and daily functioning can be significantly improved by treatment their own doctors can initiate. For employers, managed care organizations, and insurers: good outcomes, including lower job-loss rates, can come through modest, practical programs in primary care settings.

Implementing *Partners in Care*

PIC is an integrated approach to improving depression care that includes support for assessment, patient self-management, treatment choice, and case management. PIC helps clinicians focus expensive treatment on patients with major depression and provide other care for patients with depressive symptoms only.

The PIC approach is appropriate for socioeconomically and ethnically diverse populations, and can be successfully implemented by clinicians in nonacademic managed care settings.

The PIC package contains all the components needed to implement the quality-improvement programs: training materials; guidelines to help clinicians, nurses, and psychotherapists perform their functions; pamphlets and videos to educate patients; and manuals for patients in group or individual therapy.

The Design of *Partners in Care*

Partners in Care is designed to evaluate how two evidence-based quality-improvement programs for depression, as implemented by managed, primary care practices, affect quality of care, health-related outcomes, and employment. Results summarized here are based on data from follow-up one year after the programs were implemented.

Six nonacademic managed care organizations participated in the study. They are geographically diverse, and include both public and private organizations, and staff and network practice models. One of them is located in the poorest county in the country; another is in one of the wealthiest.

The study randomly assigned the 46 participating medical clinics in these managed care organizations either to conduct care as they usually would or to participate in programs that promoted quality improvement for medication or for psychotherapy. Nearly all of the primary care clinicians in the clinics agreed to take part in the study. More than 27,000 patients were screened for depressive disorders. About 1,350 eligible patients agreed to enroll. Nearly one-third were Mexican-American, an ethnic group thought to have higher rates of depression than other groups, but rarely studied.

The study's approach resembles resource management and education more than a typical clinical trial. Each participating clinic nominated leaders—a primary care provider, a nursing supervisor, and a mental health specialist. The study team trained these leaders to supervise the staff implementing the quality-improvement programs, educate primary care clinicians about the programs, provide clinical consulting, and guide the programs' implementation. The leaders were given both written and videotaped educational materials, including slides for experts to use when giving lectures on depression; pocket-size cards for the primary care physicians, containing an algorithm for diagnosing and treating depression; and a training manual, based on national practice guidelines, for nurses and psychotherapists. These latter groups also received detailed logging and tracking materials to ensure accurate patient follow-up.

Both quality-improvement programs followed a collaborative care model, involving empowerment of patients, case management by nurses, and teamwork between primary care clinicians and mental health specialists. Each patient's care began with an assessment, education, and patient-activation visit with a trained depression nurse, who then communicated the results of this assessment to the patient's primary care clinician. In the medication-oriented program, the depression nurse continued to be available to case-manage patients on medications for six or twelve months. In the psychotherapy-oriented program, the depression nurse was not available to case-manage the patient after the initial assessment. Instead, equivalent resources in the form of reduced co-payment for care were devoted to encouraging brief psychotherapy with study-trained therapists.

No one told the clinics, clinicians, or patients what to do. They were encouraged to follow their own goals. Physicians and patients were informed about both medication and therapy, but they were free to make their own choice. In effect, the practices were trained to improve themselves.

For more information:

Rubenstein, Lisa V., Maga Jackson-Triche, Jürgen Unützer, Jeanne Miranda, Katy Minnium, Marjorie L. Pearson, and Kenneth B. Wells. 1999. "Evidence-Based Care for Depression in Managed Primary Care Practices." *Health Affairs* 18(5):89–105. (Also available as RAND Reprint RP-841.)

Wells, Kenneth B., Catherine D. Sherbourne, Michael Schoenbaum, Naihua Duan, Lisa S. Meredith, Jürgen Unützer, Jeanne Miranda, Maureen Carney, and Lisa V. Rubenstein. 2000. "Impact of Disseminating Quality Improvement Programs for Depression in Primary Care: A Randomized Controlled Trial." *Journal of the American Medical Association* 283(2):212–220.

Key publications describing the study approach and presenting analytic findings are listed on page 5. Additional information about *Partners in Care* can be found on its web site at *http://www.rand.org/organization/health/partners.care/portweb.*

Five percent more of the patients in the quality-improvement programs remained in the workforce at 12 months than did their care-as-usual counterparts.

How *Partners in Care* Affects Patients' Lives

Evaluation of the *Partners in Care* programs relies on data from study records and from surveys of expert leaders, primary care physicians, and patients in the quality-improvement programs.

The quality-improvement programs significantly increased the rates of counseling and appropriate use of antidepressant medication (see Figure 1). In particular, among patients initially not in treatment for depression, participants in the quality-improvement programs were about twice as likely to start either type of treatment in the first six months of follow-up than were patients in the care-as-usual clinics. Patients in the intervention programs were also 10 percentage points less likely to be clinically depressed over the year and reported better quality of life (see Figure 2).

Even more striking from a policy perspective is how the programs affect employment. For patients who were employed when the study began, the programs promote continued employment. Five percent more of the patients in the quality-improvement programs remained in the workforce at 12 months than did their care-as-usual counterparts.

Remaining employed is a crude measure of productivity. However, it is particularly policy-relevant, since most private insurance is through employment. No other quality-improvement evaluation for any condition in primary care has shown that kind of positive employment boost.

A Model for Future Treatment of Depression?

Partners in Care is not a typical clinical trial, conducted in an academic setting. It was designed to evaluate the effectiveness of quality-improvement programs that were implemented in typical practice settings, and thus could be readily disseminated and replicated. These programs require only a modest investment in resources, permit flexibility in implementation, allow patients and physicians to choose treatment, largely rely on usual reimbursement structures, and can be implemented by a practice with modest support from study staff. The diversity of the patients and the managed care organizations that participated suggests that the study findings may be broadly applicable.

The study is ongoing, and the research team is now analyzing data from the second year of follow-up, as well as conducting a cost-effectiveness analysis. However, findings to date demonstrate that provider groups and managed care companies can benefit patients, employers, and society if they make reasonable efforts to organize treatment.

Figure 1.
Patients in the Quality-Improvement Programs Are More Likely to Receive Treatment for Depression . . .

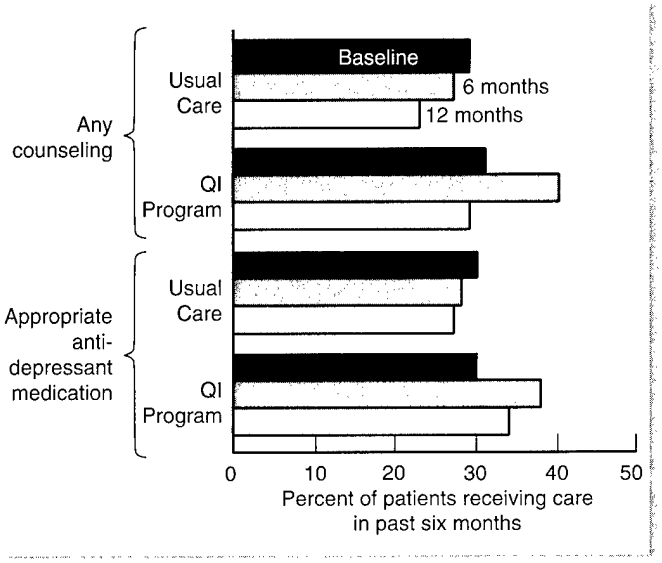
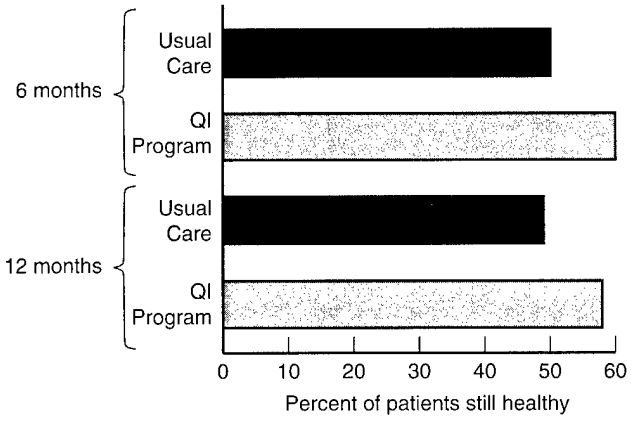


Figure 2.
. . . and Are More Likely to Remain Healthy



For more information about the *Partners in Care* quality-improvement programs, or to order PIC materials, call RAND Distribution Services, toll-free, at (877) 584-8642 or visit *www.rand.org/organization/health/pic.products.*

Publications from *Partners in Care*

Kaplan, S.H., D. Chang, J. Abe-Kim, and D.T. Takeuchi. 1998. "Ethnicity and Mental Health." In *Encyclopedia of Mental Health*, D. Friedman, ed. San Diego, Calif.: Academic Press.

Lenert, L.A., J.R. Treadwell, and C.E. Schwartz. 1999. "Associations Between Health Status and Utilities: Implications for Policy." *Medical Care* 37(5):479-489.

Meredith, L.S., L.V. Rubenstein, K. Rost, D.E. Ford, N. Gordon, P. Nutting, P. Camp, and K.B. Wells. 1999. "Treating Depression in Staff-Model vs. Network-Model Managed Care Organizations." *Journal of General Internal Medicine* 14(1):39-48.

Rubenstein, L.V., M.E. Jackson-Triche, J. Unützer, J. Miranda, K. Minnium, M.L. Pearson, and K.B. Wells. 1999. "Evidence-Based Care for Depression in Managed Primary Care Practices." *Health Affairs* 18(5):89-105. (Also available as RAND Reprint RP-841.)

Sherbourne, C.D., R. Sturm, and K.B. Wells. 1999. "What Outcomes Matter to Patients? A Study of Patient Preferences in Primary Care." *Journal of General Internal Medicine* 14(6):357-364.

Sugar, C.A., R. Sturm, T.T. Lee, C.D. Sherbourne, R.A. Olshen, K.B. Wells, and L.A. Lenert. 1998. "Empirically Defined Health States for Depression from the SF-12." *Health Services Research* 33(4):911-928.

Takeuchi, D.T., E. Uehara, and G. Maramba. 2000. "Cultural Diversity and Mental Health Treatment." In *The Sociology of Mental Health and Illness*, A. Horowitz and T. Scheid, eds. Cambridge: Cambridge University Press.

Wells. K.B. 1999. "The Design of Partners in Care: Evaluating the Cost-Effectiveness of Improving Care for Depression in Primary Care." *Social Psychiatry and Psychiatric Epidemiology* 34:20-29.

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Wells, K.B., and C.D. Sherbourne. 1999. "Functioning and Utility for Depression Compared to Chronic Medical Conditions in Primary Care, Managed Care Patients." *Archives of General Psychiatry* 56(10):897-904.

Wells, K.B., C.D. Sherbourne, M. Schoenbaum, N. Duan, L.S. Meredith, J. Unützer, J. Miranda, M. Carney, and L.V. Rubenstein. 2000. "Impact of Disseminating Quality Improvement Programs for Depression in Primary Care: A Randomized Controlled Trial." *Journal of the American Medical Association* 283(2):212-220.

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